CABRINI MEDICAL CENTER ..7 EAST 19TH ST New York NY 10003

EMERGENCY ROOM • OUTPATIENT RECOR[D]

Field	Value
SUB TYPE	
SERVICE	EMER RM
PATIENT NUMBER	443204
PATIENT NUMBER	443204
TYPE	3
PATIENT NAME	FROMETTA ADDONNA
AGE	38
BIRTHDATE	3/25/1968
SEX	F
M/S	SH
DATE OF SERVICE	2/14/07
TIME	05:51
CLERK INIT.	CMW
ADDRESS - LINE 1	666 EAST 233RD ST
ADDRESS - LINE 2	APT 1A
CITY	BRONX
STATE	NY
ZIP CODE	10466
TELEPHONE	718-881-3716
PATIENT SS#	058686478
NOTIFY IN CASE OF EMERGENCY - NAME	NADIA FABIAN
RELATIONSHIP	MOTHER
ADDRESS	
TELEPHONE	718-881-3716
INSURANCE COMPANY	NO FAULT -O/P
CONTRACT OR GROUP NUMBER	058686478
DATE	2/14/07
PLACE	NO FAULT INS - A
TIME	4:20
EVENT	AMBULANCE
GUARANTOR NAME	FROMETTA ADDONNA
GUARANTOR ADDRESS	666 EAST 233RD ST
CITY	BRONX
STATE	NY
ZIP CODE	10466
GUAR. TELEPHONE	881-3716
GUARANTOR EMPLOYER	
GUARANTOR OCCUPATION	INDEPENDENT CO
GUAR. EMPLOYER ADDRESS	
GUAR. EMPL TELEPHONE	
PREV. SERVICE	
PREV. SERV. DATE	
IF MINOR - PARENT NAME	
RELIGION	ROMAN CATHOLIC
MED. REC. #	763782
ADMITTING/2ND PHYSICIAN	BUTTERFASS/BUTTERFASS

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT, ASSIGNMENT OF INSURANCE BENEFITS

The undersigned has been informed of the emergency treatment considered necessary for the above named patient, and that treatment and procedures will be performed by physicians, members of house staff and [illegible] of the hospital. Authorization is hereby granted for such treatment and procedures. The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the results that may be obtained. [illegible] pay for services rendered by hospital upon release of patient. [illegible] hospital benefits, sick benefits, injury benefits due to a liability of a third party, payable by any party, for the above patient, to Hospital unless I pay the account in full upon release of patient. [illegible] from its records any information requested by the before mentioned insurance companies in connection with the above assignment. I do hereby [illegible] checks made payable to [illegible] for benefits or claims collected under the above assignment and to apply any credit balance to any other [illegible] said hospital.

TIME

SIGNED PATIENT [signature]

SIGNED GUARANTOR

CHIEF COMPLAINT (If Accident State How, When, and Where)
CAR CRASH ID ATT/ SEE COMM

TEMP.	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - HOME

NURSES NOTES:

E.R. PHYSICIAN

TET. TOX.

LAB DATA (Including X-Rays, EKGs, etc.)

NURSE'S SIGNATURE (RN OR LPN)

PHYSICIAN'S REPORT

DIAGNOSIS:

TREATMENT:

INSTRUCTIONS TO PATIENT:

CONDITION ON DISC: IMP | STABLE | EXPIRED

FOLLOW-UP WITH M.D.

PATIENT'S SIGNATURE ON DISCHARGE
BY SIGNING HERE I CERTIFY THAT I UNDERSTAND THE FOLLOW-UP INSTRUCTIONS RECEIVED BY ME IN WRITING, WHICH WERE EXPLAINED TO ME.

DATE - TIME OF DISC.

PHYSICIAN'S SIGNATURE M.D.

01 Cabrini Medical Center

EMERGENCY NURSING RECORD MVC

TRIAGE DATE 2/14/07 TIME 0110
emergent urgent non-urgent fast track

NAME: TRUMPETA, ANANTA
D.O.B: 3/25/68 AGE: 38 M / F
HISTORIAN: patient paramedics family
ARRIVAL MODE: car EMS police CABRINI
PMD: none
Primary language of pt ENGLISH interpreter
^IMMUNIZATIONS: current / referral
tetanus flu pneumovax

TREATMENT PTA see EMS report IV O2 c-collar backboard
last blood glucose

VITALS Glucose finger stick
Approx Height Approx Weight
BP 146/87 P 91 RR 20 temp 97.9 EM O R Ax
SaO2 100 RA O2 GCS

PAIN LEVEL current: 7 /10 max /10 acceptable /10
scale used quality
location NECK / BACK type DULL

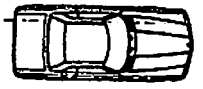
CHIEF COMPLAINT MVC
occurred just PTA At work hrs / days ago

INJURIES / PAIN

		R		L	
head	neck	shldr	hip	shldr	hip
face	back	arm	thigh	arm	thigh
nose	chest	elbow	knee	elbow	knee
mouth	abdomen	f-arm	leg	f-arm	leg
coccyx		wrist	ankle	wrist	ankle
		hand	foot	hand	foot
		fingers	toes	fingers	toes

CRASH
driver / passenger front back
lap belt / shoulder / car seat
air bag deployed UNK
walking at scene
lost consciousness
thrown from vehicle
long extrication

SITE OF IMPACT
"P" = primary "S" = secondary



speed low mod. high
direct glancing

ALLERGIES NKDA
drug - PCN / ASA / sulfa / latex / codeine / iodine
food -

MEDS none see med list OTC herbal BENTEX

PAST MEDICAL HX negative
heart disease / HTN / diabetes: insulin
past surgeries none BREAST IMPLANTS

SOCIAL HX / SCREEN drugs / alcohol RARE
smoker ppd ☐ smoking cessation provided
^TB exposure / symptoms
^has been physically hurt or threatened by someone close
If yes social worker needed

ISOLATION SCREEN
In the past two weeks, patient:
1. __had a fever
2. __had a cough or rash
3. __had shortness of breath or difficulty breathing
If patient answered positive to 1 and 2, or 1 and 3, go to Isolation Screening Question Sheet

LNMP 1/23/07 P Ab pregnant / postmenop / hyst
☑ preg test neg / pos UNSURE

RN / PA

TIME TO ROOM: ROOM:

INITIAL ASSESSMENT TIME:

GENERAL APPEARANCE
✓ no acute distress
✓ alert
__c-collar / backboard in place
__mild / moderate / severe distress
__anxious / decreased LOC

^FUNCTIONAL / NUTRITIONAL ASSESSMENT
✓ independent ADL
✓ appears well nourished / hydrated
__assisted / total care
__obese / malnourished
__recent weight loss / gain

Fall Risk Assessment

patient has hx of falls	yes / no
medications	yes / no
physical / cognitive limitations	yes / no
patient confused / disoriented	yes / no

CHEST
✓ no evidence of trauma
__non-tender
__breath sounds nml
__laceration / abrasion / swelling
__tenderness / deformity
__wheezing / crackles / stridor
__seat belt marks

CVS
✓ regular rate
__pulses strong & equal
__skin warm, dry
__tachycardia / bradycardia
__pulse deficit
__pale / cyanotic / cool / diaphoretic

NEURO
✓ oriented x 3
__PERRL
__disoriented to person / place / time
__confused / memory loss
__pupils unequal R L
__weakness / sensory loss

HEAD / FACE
__no evidence of trauma to head / eye / ear / face
__laceration / abrasion / swelling / ecchymosis
__periorbital swelling / hematoma
__dental injury / malocclusion

NECK / BACK
__no evidence of trauma
__laceration / abrasion / swelling / tenderness

ABDOMEN
✓ no evidence of trauma
__soft, non-tender
__laceration / abrasion / swelling
__rigid / distended / tenderness

PELVIS / GU
✓ no evidence of trauma
__pelvis stable
__laceration / abrasion / swelling
__pelvis unstable
__tenderness
__blood at urethral meatus

EXTREMITIES
✓ no evidence of trauma
✓ non-tender
__sensation / motor intact
__laceration / abrasion / swelling
__tenderness / deformity
__sensory / motor deficit

ADDITIONAL FINDINGS
- pt. took ADVIL 400 mg @ 11 pm

INITIAL ACTIONS

TIME			INIT
	ID band applied	ID band verified	✓
	c-collar	backboard	
	disrobed / gowned	blanket provided	
	ice pack	elevation / immobilization	
	bandage applied	wet to dry dressing	
✓	bed low position	side rails up x1 x2	
	call light in reach	head of bed elevated	

Nurse / PA

^ protocol available

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Cabrini Medical Center
EMERGENCY PHYSICIAN RECORD
MVA (5)

[illegible handwriting]

DATE: 2/14/07 TIME: 7 Am ☐ on arrival
ROOM: 3 EMS Arrival
HISTORIAN: patient spouse paramedics ACR
AGE 38 M / F
__HX / __EXAM LIMITED BY:

HPI

chief complaint: MVA **Injury to:** Neck / [illegible]

occurred: just prior to arrival

position in vehicle: driver passenger front back

context: car collision overturned vehicle
single-car accident (lost control / fell asleep / unknown cause)
[illegible handwriting]

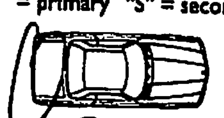
location of pain / injuries?
head face mouth
neck chest abdomen
back upper mid- lower
radiating to (R / L) thigh / leg

-right-		-left-	
shldr	hip	shldr	hip
arm	thigh	arm	thigh
elbow	knee	elbow	knee
f-arm	leg	f-arm	leg
wrist	ankle	wrist	ankle
hand	foot	hand	foot

severity of pain:
mild
moderate
severe

associated symptoms:
lost consciousness / dazed
duration:
remembers:
impact coming to hospital
seizure

site of impact:
"P" = primary "S" = secondary



force low mod. high
direct glancing

restraints:
none lap / shoulder
doesn't recall
car seat
air bag deployed
thrown from vehicle
ambulated at scene
long extrication

ROS
loss feeling / power arms / legs
memory loss
headache / neck pain
double vision / hearing loss
nausea / vomiting
abdominal pain

trouble breathing / chest pain
loss of bladder function
skin laceration
recent fever / illness
pregnant / confirmed w/ home test
☐ all systems neg except as marked

SOCIAL HX smoker drug use / abuse
recent ETOH

PAST HX __negative diabetes Type I Type 2 diet / oral / insulin

Meds- __none / see nurses note
Allergies- __NKDA / see nurses note

☐ Nursing Assessment Reviewed ☐ Vitals Reviewed ☐ Tetanus immun. UTD

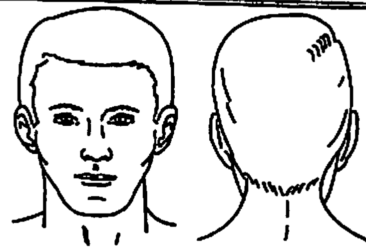
PHYSICAL EXAM
V/S T 97.7 P 91 R 20 BP 146/87

General Appearance
__no acute distress
__alert
__c-collar (PTA / in ED) / backboard
__mild / moderate / severe distress
__anxious / lethargic

HEAD
__no evidence of trauma
__see diagram
__Raccoon eyes / Battle's sign

NECK
__non-tender
__painless ROM
__trachea midline
__see diagram
__vertebral point-tenderness
__muscle spasm / decreased ROM
__pain on movement of neck

__Nexus criteria neg
__midline tenderness / distracting injury
__altered mental status
__recent ETOH



EYES
__PERRL
__EOMI
__unequal pupils R-__mm L-__mm
__EOM entrapment / palsy
__subconjunctival hemorrhage

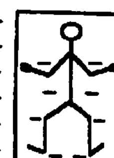
ENT
__nml external inspection
__no dental injury
__hemotympanum
__TM obscured by wax
__clotted nasal blood
__dental injury / malocclusion

RESP / CVS
__chest non-tender
__no ecchymosis
__breath sounds nml
__heart sounds nml
__see diagram (on reverse)
__tenderness / seat belt bruising
__crepitus / subcutaneous emphysema
__splinting / paradoxical movements
__decreased breath sounds
__wheezes / rales / rhonchi
__tachycardia / bradycardia

ABDOMEN
__non-tender
__no organomegaly
__no distention
__see diagram (on reverse)
__tenderness / guarding / rebound
__mass / organomegaly
FHT's

GENITAL / RECTAL
perineal hematoma
[illegible]

NEURO / PSYCH
__oriented x3
__mood & affect nml
__CN's nml as tested
__sensation & motor nml
__confused / disoriented
__facial asymmetry
__unsteady / ataxic gait
__sensory / motor deficit
__repeats questions



Glasgow Coma Score SCORE=
Eyes Open- spontaneously (4) to voice (3) to pain (2) none (1)
Speech- nml (5) disoriented (4) inapprop. (3) incoherent (2) none (1)
Motor- nml (6) localizes (5) withdraws (4) flexor (3) exten (2) none (1)

CABRINI MEDICAL CENTER

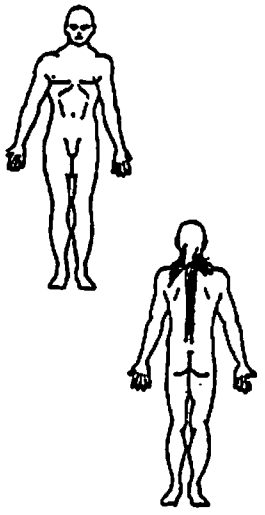
COMPREHENSIVE PAIN ASSESSMENT

Frometa, Adonna

☑ Emergency Department ☐ Ambulatory Services
☐ Hospice ☐ Inpatient Unit: _____
☐ Other: _____

INSTRUCTIONS: Complete when pain is not controlled at time of assessment.

- **Source of Information:** ☑ Patient ☐ Significant Other/Family ☐ Nursing Assessment - Patient unable to verbalize
  ☐ Other: _____
- **Pain Location:** Mark Sites



- **Patient's Pain Intensity Rating**
  ☑ 0-10: 9
  ☐ Smile - Sad _____
  ☑ Verbal: _____
  ☐ Behavioral Indicators
- **Physical Findings**
  ☐ None ☑ Tender
  ☐ Red ☐ Spasm
  ☐ Swollen ☐ Hot
  ☐ Ecchymotic
  ☐ Other: _____
- **Pain Characteristics** Circle all that apply:
  Aching, Dull, Deep, Sharp, Gnawing, Numb, Stabbing, Crampy, Pressure, Squeezing, Burning, Radiating, Tingling, Touch Sensitive.
  Tight!
- **Is the Pain:**
  ☑ Constant
  ☐ Intermittent
- **Behavioral Indicators:** Circle all that apply:
  Frowning, Grimacing, Clenched Fists, Hostility, Crying, Moaning, Depression, Gritting Teeth, Restlessness, Clutching/Rubbing Affected Part, Fetal Position, Increased Muscle Tension.

- **Pain Intensity Goal: (0 - 10)** 0
- **When did pain start?** At 3 a.m.
- **Pain Control Goal:**
  ☐ sleep comfortably ☐ comfort at rest ☐ comfort with movement ☐ stay alert
  ☑ total pain control ☑ perform activity ☐ other _____
- **What makes the pain worse?** movement
- **Chronic/Pre-existing Pain - What relieves pain?** (Check all that apply.)
  ☐ medication ☐ exercise ☐ bed rest ☐ cold
  ☐ heat ☐ massage ☐ distraction ☐ relaxation techniques
  ☐ acupuncture ☐ other _____
- **Has there been any medication you have taken that has been effective?** no
- **What have you done in the past that has been effective in relieving your pain?** _____
- **Adverse Affect on Daily Life and Activities - Does the pain affect your day to day activities?** (Check all that apply.)
  ☐ walking ☐ sitting ☐ standing ☐ exercise ☐ relationships
  ☐ work ☐ bathing ☐ cooking ☐ shopping ☐ other _____
  ☐ family ☐ sleep ☐ concentration ☐ intimacy ☐ other _____
- **Comments:** _____

- **Name of MD Notified:** Dr. Hernandez
- **Signature & Title:** _____ Time: 0520 AM PM Date: 2/19/05

ANNABELLE PEDRINA-QUEZADA, RN

CMC-2036 (09/01)

CABRINI
MEDICAL CENTER
227 East 19th Street, New York, NY 10003

PHYSICIAN'S ORDERS

DOCTOR: USE BALLPOINT PEN ONLY.
START NEW SECTION FOR EACH SET OF ORDERS
INCLUDE DATE, TIME AND SIGNATURE FOR EACH
SET OF ORDERS.

Frazetta
Adjora

ALLERGIES: ______________________

DO NOT USE THIS SHEET
UNLESS A RED NUMBER SHOWS →

	MEDICATION (Including Diluent) Name, Dose or Strength, Formulation, Route, Frequency, Duration	Indication Rationale or Reason	
DATE: 2/14/07	1. Robaxin 1g PO x1		U.C
6:40	2. Soft collar		DATE
TIME: pm	3.		TIME
	4.		
PHYSICIAN'S SIGNATURE [signature]	PAGE/ID #	R.N. SIGNATURE [signature] Verbal Order Read Back [ ]	DATE: 2/14/07	TIME 6:45

DATE:	1.		U.C
	2.		DATE
TIME:	3.		TIME
	4.		
PHYSICIAN'S SIGNATURE	PAGE/ID #	R.N. SIGNATURE Verbal Order Read Back [ ]	DATE:	TIME

DATE:	1.		U.C
	2.		DATE
TIME:	3.		TIME
	4.		
PHYSICIAN'S SIGNATURE	PAGE/ID #	R.N. SIGNATURE Verbal Order Read Back [ ]	DATE:	TIME

DATE:	1.		U.C.
	2.		DATE
TIME:	3.		TIME
	4.		
PHYSICIAN'S SIGNATURE	PAGE/ID #	R.N. SIGNATURE Verbal Order Read Back [ ]	DATE:	TIME

THE SIGNATURE OF THE PRESCRIBER MUST ACCOMPANY EACH ORDER ALONG WITH THEIR PRINTED NAME AND ID #

Authorization Is Given To Dispense Medication By Generic Or Therapeutic Equivalent If Such Is Determined By The Pharmacy And Therapeutics Committee. A Non-Formulary Request Form Is Required If Medications Are Not Included In The Formulary.

CMC 058 (Rev.3/06)

CHART COPY

Cabrini Medical Center

ACKNOWLEDGMENT AND CONSENT

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND OPERATIONS

By signing below, I acknowledge that a copy of the Notice of Privacy Practices has been made available to me. I have been advised of how my health information may be used and disclosed by the hospital and the facilities listed at the beginning of the notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices (see: Appendix A) explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information:

- *to treat me and arrange for my medical care*
- *to seek and receive payment for services given to me*
- *for the business operations of the hospital, its staff, and the facilities listed at the beginning of the notice*

X Adonia Fronte
Signature of Patient or Personal Representative

2/14/07
Date

I, Adonia Fronte
Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Witness

For Hospital Use Only:

If form is not completed, state the reason:

CMC Employee Signature

Date

Print First and Last Name

Acknowledgement

- I acknowledge receipt of the booklet, *Your Rights as a Hospital Patient in New York State,* prepared by the New York State Department of Health.
  - ☑ Patient's Bill of Rights
  - ☑ An Important Message Regarding Your Rights as a Hospital Inpatient
  - ☑ Admission Notice to Medicare Beneficiaries
  - ☑ Important Message from Medicare
  - ☑ Planning in Advance for Your Medical Treatment (an explanation of Advance Directives)
  - ☑ Deciding about CPR: Do-Not-Resuscitate (DNR) Orders – A Guide for Patients and Families
  - ☑ Appointing Your Health Care Agent – New York State's Proxy Law
  - ☑ Health Care Proxy Form
  - ☑ Letter from the New York State Department of Health (explains the SPARCS data collection system)

- Additional Information:

☑ Organ Donation ☑ Pain Management ☑ Home Care Provider

X Adora Flores

Patient's Signature
or

_____

Signature of Patient's Designated Representative

_____

Indicate relationship to patient

A hospital representative

☐ was ☐ was not

present to answer my questions about this booklet.

This will become part of your permanent hospital record.

Day Division
Mon-Fri: 8am-11am, 5pm-8pm (EST)
Sat-Sun: 8am-8pm (EST)
Phone: 866 329 4295 Fax: 877 899 4295

NightHawk
Radiology Services

Night Division
Mon-Fri: 8pm-8am (EST)
Sat-Sun: 8pm-8am (EST)
Phone: 866 241 6635 Fax: 866 287 1373

PRELIMINARY RADIOLOGY REPORT

PATIENT NAME: FROMETTA, ADDONNA

PATIENT ID: 763782

INSTITUTION NAME: CABRINI MEDICAL CENTER - NEW YORK, NY 10003

DATE: 14th February, 2007 EST

STUDY TYPE: CT BRAIN

ACCESSION NUMBER: N/A

This interpretation is based upon the receipt of 75 images.

Patient Location: ER (Emergency Room)
Patient Location Floor: N/A

Patient Location Room: N/A
Patient Location Bed: N/A

CLINICAL HISTORY / INDICATION FOR EXAM:

MVA WITH HEAD TRAUMA

FINDINGS:

Noncontrast CT Head:

Noncontrast axial images obtained through the head.

Ventricles, basilar cisterns and cortical sulci are within limits. There is no evidence of mass effect or midline shift. No acute hemorrhage identified. No abnormal intra-axial or extra-axial fluid collections are appreciated. Brain parenchyma is of normal density and gray-white matter differentiation. Soft tissues and osseous structures are unremarkable.

Preliminary report created by: Edward Callaway MD

Cabrini Medical Center - Emergency Department
227 E 19th Street New York, NY (212) 995-6620
ADDONNA FROMETTA, Med. Rec. No.: 763782 02/14/2007 06:43

IMPORTANT: We examined and treated you today on an emergency basis only. This was not a substitute for, or an effort to provide, complete medical care. In most cases, you must let your doctor check you again. Tell your doctor about any new or lasting problems. We cannot recognize and treat all injuries or illnesses in one Emergency Department visit. If you had special tests, such as EKG's or X-rays, we will review them again within 24 hours. We will call you if there are any new suggestions. After you leave, you should **follow the instructions below.**

You were treated today by ELIEZER HERNANDEZ, M.D..

THIS INFORMATION IS ABOUT YOUR FOLLOW UP CARE
Call as soon as possible to make an appointment in 1 day at the Cabrini East Village/CEV. You can reach the Cabrini East Village/CEV at (212) 979-3200, 97 E. 4th Street, New York, NY. If you have any problems or concerns before the appointment, call the Clinic. Office Hours are Monday through Friday 9 am to 5 pm.

THIS INFORMATION IS ABOUT YOUR DIAGNOSIS
TORTICOLLIS (Wry neck).
Your neck muscles have become overstretched. The stretched muscles cramp (spasm). The muscle pain can also cause a headache.

Do the following:
- Apply warm packs to relax the neck muscles. Do this 3 to 4 times a day for 20 minutes.
- Avoid strenuous activities until your pain is gone.

Call your doctor if:
- you have increased neck pain or headache after treatment.
- you have any new or severe symptoms.

HEAD INJURY
You've had a head injury. Your skull and/or brain were affected.

Follow these instructions:
- A family member or friend should wake you up every two hours throughout the first night at home. When they wake you, they should ask you your name, where you are, and what day it is. If you cannot answer these questions, they should call your doctor.
- If you have a headache, sleep with your head raised on a few pillows.
- Rest for a day or two. You can return to your normal activities as you feel able.
- If you are sick to your stomach, avoid heavy foods. Nausea should clear up in a day or two.
- Keep follow-up appointments with your doctor.
- Take any medicines ordered for you by your doctor as scheduled.

Call your doctor if:
- your headache gets worse or is not relieved by acetaminophen.
- you have problems talking.
- you have difficulty hearing.
- you have any change in your vision.
- you lose your balance or have trouble walking.
- you have trouble thinking clearly.
- you have forceful vomiting.
- you have any questions or concerns.

Your family or friend should call your doctor or take you to the Emergency Department if:
- you become confused and cannot state your name, where you are, or what day it is.
- they have difficulty waking you.
- you have a seizure.

Sometimes after even a minor head injury, people notice signs and symptoms that show up as long as one year after the injury. These signs and symptoms include:
- Decreased concentration
- Difficulty learning
- Memory problems
- Vision changes
- Headaches, especially with stress or physical activity
- Mood changes
- Increased sensitivity to noise
- Dizziness
- Difficulty in relationships with other people
- Decreased interest in sex
- Increased susceptibility to alcohol (becoming intoxicated or drunk more easily)

If you notice any of these symptoms over the next year and are concerned about them, talk with your doctor.

For more information related to head injuries, contact:
The Brain Injury Association of America
www.biausa.org
1-800-444-6443

What is smoking cessation?
Smoking cessation is quitting smoking. Smoking is a very difficult habit to break for most people. The chemical, nicotine, which you inhale into your lungs from a cigarette, causes your brain to have more dopamine. Dopamine is a chemical that makes you feel good. Smoking makes you feel good. But nicotine also has many more harmful effects on your body. This is why it is so important to stop smoking. Nicotine is addictive, which means when your body is used to having nicotine, and then nicotine isn't there, you feel strong physical cravings and a need to smoke. This is why stopping smoking is so difficult.

Why is smoking bad for me?

YOU ARE THE MOST IMPORTANT FACTOR IN YOUR RECOVERY. Follow the above instructions carefully. Take your medicines as prescribed. Most important, see a doctor again as discussed. If you have problems that we have not discussed, call or visit your doctor right away. If you cannot reach your doctor, return to the Emergency Department.

"I have received this information and my questions have been answered. I have discussed any challenges I see with this plan with the nurse or physician."

ADDONNA FROMETTA or Responsible Person

ADDONNA FROMETTA or Responsible Person has received this information and tells me that all questions have been answered.

Physician/RN Staff Signature

\11PI\

CABRINI MEDICAL CENTER
227 EAST 19th STREET
NEW YORK, NY 10003

DIAGNOSTIC IMAGING

---------NAME---------	NUMBER	SEX	AGE	ADMIT	DISC.	XRAY#	P/C	TYPE
FROMETTA ADDONNA	443204	F	38	2/14/07		763782	WB4	E/R

DATE OF BIRTH: 03/25/1968 M/R# 763782 PH#: 718-881-3716 RM
LOCATION:
TRANSCRIBED: 2/14/07 10:49 PSR
CT HEAD W/O CONTRAST 70450 COMPLETE: 02/14/07 6:25 VL 7902
{CT REASON Trauma
PHYSICIAN: BUTTERFASS

Unsigned transcriptions represent a preliminary report and do not reflect
*** a medical or legal document ***

Comparison: None

History: Motor vehicle accident

Procedure: Sequential axial CT images are obtained at 5 mm intervals from the level of the foramen magnum to the vertex. Images are displayed in brain, blood, and bone windows.

Findings: There is no evidence of intracranial mass or midline shift. There are no focal parenchymal lesions within either cerebral hemisphere. There are no abnormal intra-axial or extra-axial fluid collections. The ventricles, cisterns and sulci are normal for the patient's stated age. There is normal gray-white differentiation of both cerebral hemispheres. There is no evidence of acute intracranial hemorrhage or infarction. The cerebellum, thalami, midbrain, pons and basal ganglia are grossly normal.

The bones of the skull base as well as the calvaria are intact. The visualized portions of the paranasal sinuses and mastoid air cells are normal.

Impression: Normal examination.

Dictated By: 190400 Marina Margolina M.D.
Signed By: 190400 Marina Margolina M.D.
Dictated On: 02/14/2007 10:19:07

02/14/07 10/18

ELECTRONICALLY REVIEWED AND SIGNED BY
MARINA MARGOLINA
RADIOLOGIST

PARTICIPATING MEMBER 911 AMBULANCE

NYC 911 SYSTEM PROVIDER AMBULANCE CALL REPORT

NO.: VOL- 3003169

Date MMDDYYYY	Unit	Unit Type (ALS / BLS)	Shield Driver	Shield Tech	CAD No.	Responded From
04/14/2007	06 [illegible]	BLS	[illegible]	1443	0376	15 [illegible] / 2nd Av

Call Location	Boro	Apt.	PD Badge Number	Precinct	Call Type
E 23rd St / Lexington	M	—		13	MVA

Patient's Last Name	First Name	Sex (☐M ☐F)	Age	DOB MMDDYYYY
FIKIMETHA	ADAMNA		35	03/29/1968

Home Address	Apt.	Social Security Number
166 E 23rd St	7A	[illegible]

City	State	Zip Code	Next of Kin	Telephone
[illegible]	NY	10016	None	718 881-3716

Prior Treatment at Scene / By Whom

Prior: ☐ Defibrillation(s), No.:____ ☐ CPR, Mins.:____

By: ☐ PD ☐ FD ☐ Other:

REC'D	0	4	3	5
10-63	0	4	3	5
10-84	0	4	4	1
10-82	0	5	0	0
10-81	0	5	0	1
AVAIL	0	5	2	5

CHIEF COMPLAINT: [illegible]

MILEAGE: 1

PRESENTING PROBLEM

MEDICAL *If more than one is checked, circle the primary problem*

☐ Airway Obstruction ☐ Abdominal pain ☐ Allergic Reaction ☐ Altered Mental Status ☐ Behavioral ☐ Cardiac Arrest ☐ Chest pain ☐ CVA / TIA ☐ Dehydration ☐ Dizziness ☐ Environmental: ☐ Haz-Mat ☐ Cold ☐ Heat ☐ General Malaise ☐ G.I. Distress / Bleed ☐ Hemorrhage ☐ Nausea / Vomiting ☐ Newborn ☐ Obvious Death ☐ Ob/Gyn: ☐ Labor ☐ Delivery ___ : ___ ☐ Psychotic / Suicidal ☐ Respiratory Distress ☐ Respiratory Failure ☐ Respiratory Arrest ☐ Seizure ☐ Shock ☐ Syncope ☐ Unconscious ☐ Other: ☐ Overdose: ____ Substance ☐ Poison: ____ Substance ☐ Fever ☐ Rash

TRAUMA Location: [illegible] / Neck / Back Type: [illegible] ☐ Anterior ☐ Posterior

☐ Amputation ☐ Burn ☐ Thermal ☐ Chemical ☐ Electrical ☐ Cardiac Arrest ☐ C.N.S. ☐ Crush ☐ FX/Dislocation ☐ Head Trauma ☐ Hemorrhage ☐ Impaled Object ☐ Paralysis ☐ Shock ☒ Soft Tissue ☐ Other:

INDICATE ALL THAT APPLY FOR MEDICAL or TRAUMA

Onset: ____ Pain: ____ Quality: ____ Radiation: ____ Severity: ☐ Mild ☐ Mod. ☐ Severe Duration: ____

MECHANISM OF INJURY

☐ Assault ☐ Cold ☐ Domestic Violence ☐ Fall ☐ G.S.W. ☐ Hazardous Materials ☐ Suspected Child Abuse ☐ Heat ☐ Machinery ☒ MVA: Seatbelts ☒ Yes ☐ No ☐ Pedestrian Struck ☐ Stab ☐ Other: ☐ Suspected Elder Abuse

ASSESSMENT

HISTORY ☐ Denies [illegible handwriting] ☐ Amputee ☐ Asthma ☐ Bed Confined ☐ Cancer ☐ Cardiac ☐ CHF ☐ COPD ☐ CVA / TIA ☐ Diabetes ☐ Dialysis ☐ Frail/Debilitated ☐ HIV/AIDS ☐ Hypertension ☐ Incontinent ☐ IVDA ☐ Seizures ☐ TB ☐ Wheelchair Confined ☐ Other:

MEDICATIONS ☐ Denies ☐ Unknown ☐ Not Compliant

ALLERGIES ☐ Denies ☐ Unknown — PCN

TIME	B.P.	PULSE	RESP	GCS	TRAUMA #
[illegible]	128/70	70	14	15	—
[illegible]	130/70	65	14	15	—
:	/				

SKIN (1 2): Normal ☒☒ Moist ☐☐ Dry ☐☐ — SKIN TEMP. (1 2): Normal ☒☒ Warm ☐☐ Cool ☐☐ — SKIN COLOR (1 2): Normal ☒☒ Pale ☐☐ Cyanotic ☐☐ Flushed ☐☐ Jaundice ☐☐ — PUPILS (1 2): Normal ☒☒ Dilated ☐☐ R Larger ☐☐ L Larger ☐☐ Constricted ☐☐ Unreactive ☐☐ — MENTAL STATUS (1 2): Alert ☒☒ Verbal ☐☐ Painful Stimuli ☐☐ Unresponsive ☐☐

TREATMENT

AIRWAY ☐ Abdominal/Chest Thrust ☐ Modified Jaw Thrust ☐ Hyperextension ☐ Oral / Nasal ☐ Suction ☐ DeLee

OXYGEN THERAPY ☐ Bag Valve Mask w/O2 ☐ Mouth to Mask ☐ Cannula ☐ Non-Rebreather ☐ Nebulizer L.P.M.: ____

IMMOBILIZATION ☒ Backboard: ☒ Long ☐ Short ☐ KED ☒ Cervical Collar ☐ Splint: ☐ Fixation ☐ Traction ☒ Head Immobilizer ☐ Other:

BLS and ALS INTERVENTIONS ☐ Albuterol ☐ Control Bleeding ☐ Aspirin ☐ CPR ☐ SAED ☐ Epi-Pen ☐ Heat/Cold Application ☐ Ipecac ___ cc P.O. ☐ Instra-Glucose ☐ Irrigation ☐ Other: ☐ I.V. ☐ I.O. ☐ Saline Lock ☐ Monitor ☐ Defibrillate ☐ 12 Lead ☐ Cardiovert ☐ Pacing ☐ Draw Blood ☐ ET Tube ☐ NG Tube ☐ Drug Therapy ☐ Chest Decompression ☐ Needle Cricothyroidotomy ☐ ET Confirm ☐ ALS ASSESSMENT PERFORMED ALS Provided By: ☐ FD ☐ Vol. ☐ Other

Presumptive Diagnosis: Head/Neck/Back Pain

Patient Condition: ☐ Critical ☐ Unstable ☐ Potentially Unstable ☒ Stable ☐ DOA ☐ Rigor mortis ☐ Extreme Dependent Lividity ☐ Obvious Death ☐ Decomposition ☐ DNR

COMMENTS

TIME	EKG RHYTHM / MEDICATION(S)	TREATMENT / RESPONSE
	UHF 35 y/o [illegible] MVA → [illegible]	
	[illegible] LOC, [illegible]	
	[illegible]	
	[illegible]	
	[illegible]	
	[illegible]	

Control Channel: _____ | Number | Termination Time | Controlled Substance | Amount Administered

C.S. Administered By *Name/Shield* Signature | URN | Amount Wasted | Witness *Name/Title/Signature*

Removed to Vehicle By
☐ Chair ☐ Walked ☐ Carried
☐ Scoop/Flat/Stretcher
☐ [illegible]st Ambulance

Transport Position
☑ Supine ☐ Sitting
☐ Prone ☐ Restrained
☐ Shock
☐ Semi / Full Fowlers
☐ Left Lateral Recumbent

Patients Transported by this Vehicle (82)
Hosp. # [illegible]
☐ Transported to Hospital
☐ Transported to Morgue
Hospital Destination
Pts. 1

Patient Not Transported by this Vehicle
☐ Assisted In Transport (94A) With (Unit #): _____
☐ Transferred/Relinquished Care To (94)(Unit #): _____
☐ RMA/AMA (93)
☐ Pronounced on Scene (83)
☐ Triage/On Line Medical Control (93A/95/95A)
☐ Other:

Transported From
☐ Residence ☑ Public Scene
☐ Nursing Facility
☐ Res./Cust. Facility
☐ Other:

Lights & Siren Used
☑ To Scene (63)
☐ To Destination (82)

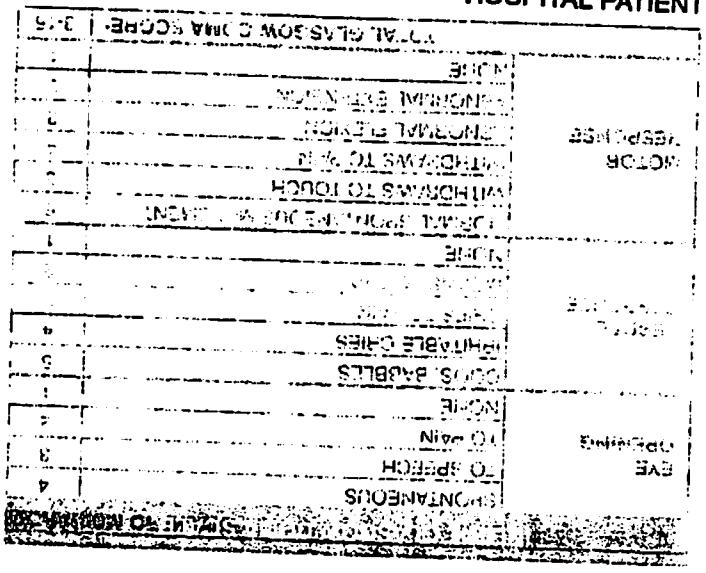
Hospital Selection
☑ Nearest ☐ Pt./Fam Choice
☐ OLMC Contract ☐ Specialty Referral
☐ Hospital Diversion From _____ Hosp. #

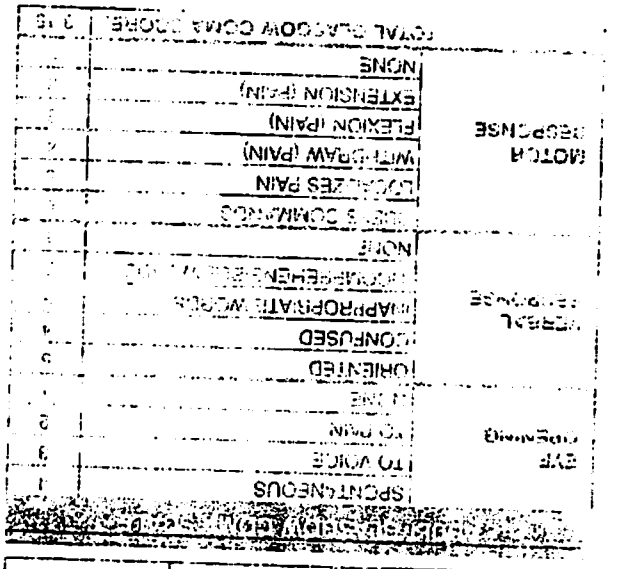
ED Chart No. | Insurance ID Number | ☐ Medicare ☐ Medicaid ☐ Blue Cross ☐ Commercial Insurance ☐ Self Pay | Work Related ☐ Yes ☐ No

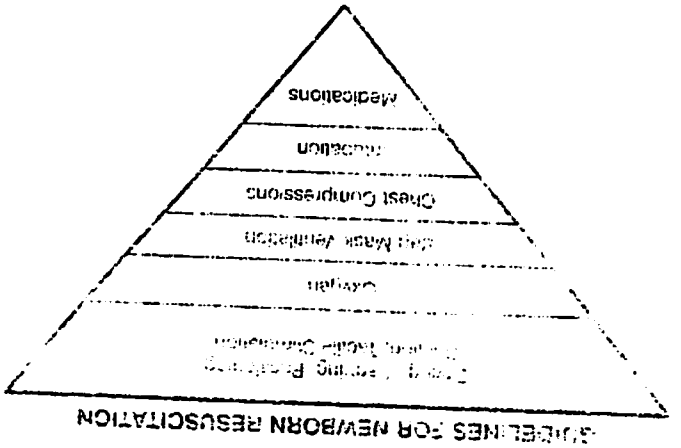
Hospital Receiving Agent Signature Time | Supervisor Signature Shield Date

EMS 102.15.01 (7/06)

HOSPITAL PATIENT RECORD COPY







SKIN COLOR	PALENESS OR BLUISH	PINK OR TYPICAL NEWBORN COLOR HANDS AND FEET ARE BLUE	PINK OR TYPICAL NEWBORN COLOR, ENTIRE BODY
RESPIRABILITY	NO RESPONSE	CRYING, SOME MOTION	CRYING VIGOROUSLY
MUSCLE TONE	LIMP	SOME FLEXION, EXTREMITIES	ACTIVE, GOOD MOTION IN EXTREMITIES
RESPIRATION	ABSENT	SLOW AND IRREGULAR	CRYING, GOOD [illegible]
HEART RATE	ABSENT	BELOW 100	OVER 100

THE APGAR SCORING SYSTEM

Score of 7 or less requires immediate intervention

universata

Authorization Validation Checklist

- ✓ Patient Name
- ✓ Signature of patient or patient's legal representative
- ✓ Date authorization was signed
- ✓ Patient DOB
- ✓ Name and address of entity holding record
- ✓ Name and address of person/entity requesting record
- ✓ Specific dates of service
- ✓ Purpose of request
- ✓ Description of information to be released
- ✓ Expiration date

ote: Please initial below upon completion of checklist and scan as last page of the request.

MW

CABRINI MEDICAL CENTER 227 EAST 19TH ST New York NY 10003

SUB - TYPE | SERVICE: EMER RM | PATIENT NUMBER: 443204

EMERGENCY ROOM • OUTPATIENT RECORD

PATIENT NUMBER	TYPE	PATIENT NAME	AGE	BIRTHDATE	SEX	M/S	DATE OF SERVICE	TIME	CLERK INIT.
443204	3	FROMETTA ADDONNA	38	3/25/1968	F	SH	2/14/07	05:51	CMW

ADDRESS - LINE 1	ADDRESS - LINE 2	CITY	STATE	ZIP CODE	TELEPHONE
666 EAST 233RD ST	APT 1A	BRONX	NY	10466	718-881-3716

PATIENT SSAN	NOTIFY IN CASE OF EMERGENCY - NAME	RELATIONSHIP	ADDRESS	TELEPHONE
058686478	NADIA FABIAN	MOTHER		718-881-3716

INSURANCE COMPANY		CONTRACT OR GROUP NUMBER	DATE	PLACE
NO FAULT	-O/P	058686478	2/14/07	NO FAULT INS - A

GUARANTOR NAME	GUARANTOR ADDRESS	CITY	STATE	ZIP CODE	GUAR. TELEPHONE
FROMETTA ADDONNA	666 EAST 233RD ST	BRONX	NY	10466	881-3716

GUARANTOR EMPLOYER	GUARANTOR OCCUPATION	GUAR. EMPLOYER ADDRESS	GUAR. EMPL TELEPHONE
	INDEPENDENT CO		

PREV. SERVICE	PREV. SERV. DATE	IF MINOR - PARENT NAME	MED. REC. #	ADMITTING/3RD PHYSICIAN
			763782	BUTTERFASS/BUTTERFASS

RELIGION	TIME	TIME	EVENT
ROMAN CATHOLIC	4:20		AMBULANCE

AUTHORIZATION FOR TREATMENT, GUARANTEE OF PAYMENT, ASSIGNMENT OF INSURANCE BENEFITS

SIGNED PATIENT: Arlene Fronte SIGNED GUARANTOR:

CHIEF COMPLAINT (If Accident State How, When, and Where)
CAR CRASH ID ATT/ SEE COMM

TEMP.	PULSE	RESP.	B/P	ALLERGIES	MEDICATIONS - NONE	E.R. PHYSICIAN	TET. TOX.

NURSES NOTES:

LAB DATA (Including X-Rays, EKGs, etc.) NURSE'S SIGNATURE (RN OR LPN)

PHYSICIAN'S REPORT

DIAGNOSIS:

TREATMENT:

INSTRUCTIONS TO PATIENT: CONDITION ON DISC: IMP | STABLE | EXPIRED

FOLLOW-UP WITH

M.D.

PATIENT'S SIGNATURE ON DISCHARGE
BY SIGNING HERE I CERTIFY THAT I UNDERSTAND THE FOLLOW UP INSTRUCTIONS RECEIVED OF IN WRITING, WHICH WERE EXPLAINED TO ME.

DATE - TIME OF DISC.

PHYSICIAN'S SIGNATURE M.D.

01 Cabrini Medical Center

EMERGENCY NURSING RECORD
MVC

TRIAGE DATE 2/14/07 TIME 0110
emergent (urgent) non-urgent fast track

NAME: TRUMPETH, ARUNA
D.O.B: 3/18/68 AGE: 38 M / (F)
HISTORIAN: (patient) paramedics family
ARRIVAL MODE: car (EMS) police UNKNOWN
PMD: none
Primary language of pt ENGLISH interpreter
^IMMUNIZATIONS: current / referral
tetanus flu pneumovax

TREATMENT PTA see EMS report IV O2 (c-collar) (backboard)
last blood glucose

VITALS Glucose finger stick
Approx Height 5'9" Approx Weight 199
BP 146/87 P 91 RR 20 temp 97.9 (TM) O R Ax
SaO2 100 (RA) / O2 GCS

PAIN LEVEL current 7 /10 max /10 acceptable /10
scale used quality
location NECK / BACK type DULL

CHIEF COMPLAINT MVC
occurred just PTA (min) hrs / days ago

INJURIES (PAIN)

			B		L	
(head)	(neck)	shldr	hip	shldr	hip
face	(back)	arm	thigh	arm	thigh
nose	chest	elbow	knee	elbow	knee
mouth	abdomen	f-arm	leg	f-arm	leg
coccyx		wrist	ankle	wrist	ankle
		hand	foot	hand	foot
		fingers	toes	fingers	toes

CRASH
(driver) / passenger front back
lap belt / shoulder / car seat
air bag deployed ND
walking at scene
lost consciousness
thrown from vehicle
long extrication

SITE OF IMPACT
"P" = primary "S" = secondary

speed low mod. (high)
direct glancing

ALLERGIES NKDA
drug - PCN / ASA / sulfa / latex / codeine / iodine
food -

MEDS none see med list OTC herbal DENIES

PAST MEDICAL HX (negative)
heart disease / HTN / diabetes: insulin
past surgeries none BREAST IMPLANTS

SOCIAL HX / SCREEN drugs / alcohol (NEG)
smoker ppd ☐ smoking cessation provided
^TB exposure / symptoms
^has been physically hurt or threatened by someone close
If yes social worker needed

ISOLATION SCREEN
In the past two weeks, patient:
1. __had a fever
2. __had a cough or rash
3. __had shortness of breath or difficulty breathing
If patient answered positive to 1 and 2, or 1 and 3, go to Isolation Screening Question Sheet

LNMP 1/23/07 P Ab pregnant / postmenop / hyst
☑ preg test (neg) pos URINE

RN / PA

TIME TO ROOM: ROOM:

INITIAL ASSESSMENT TIME:

GENERAL APPEARANCE
(no acute distress
(alert
__c-collar / backboard in place
__mild / moderate / severe distress
__anxious / decreased LOC

^FUNCTIONAL / NUTRITIONAL ASSESSMENT
(independent ADL
(appears well nourished / hydrated
__assisted / total care
__obese / malnourished
__recent weight loss / gain

Fall Risk Assessment

patient has hx of falls	yes / (no)
medications	yes / (no)
physical / cognitive limitations	yes / (no)
patient confused / disoriented	yes / (no)

CHEST
(no evidence of trauma
__non-tender
__breath sounds nml
__laceration / abrasion / swelling
__tenderness / deformity
__wheezing / crackles / stridor
__seat belt marks

CVS
__regular rate
__pulses strong & equal
__skin warm, dry
__tachycardia / bradycardia
__pulse deficit
__pale / cyanotic / cool / diaphoretic

NEURO
(oriented x 3
__PERRL
__disoriented to person / place / time
__confused / memory loss
__pupils unequal R L
__weakness / sensory loss

HEAD / FACE
__no evidence of trauma to head / eye / ear / face
__laceration / abrasion / swelling / ecchymosis
__periorbital swelling / hematoma
__dental injury / malocclusion

NECK / BACK
__no evidence of trauma
__laceration / abrasion / swelling / tenderness

ABDOMEN
(no evidence of trauma
__soft, non-tender
__laceration / abrasion / swelling
__rigid / distended / tenderness

PELVIS / GU
(no evidence of trauma
__pelvis stable
__laceration / abrasion / swelling
__pelvis unstable
__tenderness
__blood at urethral meatus

EXTREMITIES
(no evidence of trauma
(non-tender
__sensation / motor intact
__laceration / abrasion / swelling
__tenderness / deformity
__sensory / motor deficit

ADDITIONAL FINDINGS
- Pt. took Advil 400 mg @ 11 PM

INITIAL ACTIONS

TIME			INIT
	(ID band applied	ID band verified	
	c-collar	backboard	
	disrobed / gowned	blanket provided	
	ice pack	elevation / immobilization	
	bandage applied	wet to dry dressing	
	bed low position	side rails up x1 x2	
	(call light in reach	head of bed elevated	

Nurse / PA

* protocol available

3/23/2007 10:37 PM

ACTIONS

TIME		INIT
	set up suture tray eye tray	
	cardiac monitor	
	pulse oximeter O_2 ____ L via	
	Accu-Chek	
0515	ready for Dr eval notified doctor / seen by Dr	
	restraints see documentation	

IV STARTS

TIME	#	site	gauge	attempts	complications	INIT

IV / MEDICATION INFUSION RECORD

Start Time	Solution / Med	IVPB	Rate ml / hr	Stop Time	Amount Infused	INIT
	Response: no change improved					
	Response: no change improved					
	Response: no change improved					

MEDICATIONS

TIME	Medication	Dose	Route	Site	INIT
	Td / TT	0.5mL	IM		
	lot #: exp. date manufac				
634	Robaxin	1 gram	PO		BV
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				
	Response: no change improved				

PROCEDURES

TIME		INIT
	laceration repair to	
	assisted by:	
	foreign body removed assisted by:	
	assisted Dr with dislocation / fx reduction	
	shoulder elbow MTP patella	
	splint / sling applied arm leg short long	
	type:	
	assessed post-procedure	
	nml color / sensation / movement	
	lab drawn / sent by ED tech / nurse / lab	
	results back	
	cleaned wound applied abx ointment	
	applied dressing / Band-Aid / elastic wrap	
	soft collar	
	crutch training w/ proper return demonstration	
	to Xray w/ monitor / nurse / O_2 / tech	
	return to room	
640	to CT w/ monitor / nurse / O_2 / tech	BV
650	return to room	BV

MVC - 01

VITAL SIGNS

TIME	BP	P	RR	T	SaO_2	GCS	Pain	Pupils	INIT
							/10		
							/10		
							/10		
							/10		
							/10		

ADDITIONAL NOTES

634a Returned from CT scan via a/c. Left c-collar applied. Robaxin 1 gram PO given as prescribed BV

INTAKE_____ OUTPUT_____

__IV / saline lock discontinued: Total Amt Infused_____

_____ Time_____ Initials_____

PROPERTY TO:

__patient __family __security __safe __see patient belongings list

DISPOSITION

__discharged home police nursing home ME funeral home

__verbal / written instructions / RX given to: patient

__verbalized understanding

__learning barriers addressed

__accompanied by / driver

__admitted / transferred to

__report to_____ time_____

__transfer documentation completed

__notified family / police / ME

__left AMA / LWBS signed AMA sheet refused

__physician notified of:

Discharge Vitals
BP 122/72 HR 82 RR 16 Temp 97° SaO_2 97%
__pain level at discharge 2 /10

CONDITION

__unchanged __improved stable __other

Depart Time 2104 Mode walk crutches W/C stretcher ambulance

Discharge Nurse Signature BV

☐ Continuation Sheet

SIGNATURE	INITIAL
[illegible] RN	BV

* protocol available

17

Cabrini Medical Center
EMERGENCY PHYSICIAN RECORD
MVA (5)

Fiorella Adona

DATE: 2/14/07 TIME: 7 Am ☐ on arrival
ROOM: 3 __ EMS Arrival
HISTORIAN: patient spouse paramedics ACR
AGE 38 M / F
__HX / __EXAM LIMITED BY:

HPI

chief complaint: MVA Injury to: Neck / L...

occurred: just prior to arrival

position in vehicle: driver passenger front back

context: car collision overturned vehicle
single-car accident (lost control / fell asleep / unknown cause)

Car rear ended

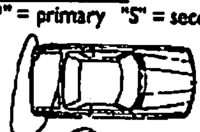
location of pain / injuries: head face mouth neck chest abdomen back upper mid- lower radiating to (R / L) thigh / leg

-right-		-left-	
shldr	hip	shldr	hip
arm	thigh	arm	thigh
elbow	knee	elbow	knee
f-arm	leg	f-arm	leg
wrist	ankle	wrist	ankle
hand	foot	hand	foot

severity of pain: mild moderate severe

associated symptoms: lost consciousness / dazed
duration:
remembers: impact coming to hospital
seizure

site of impact: "P" = primary "S" = secondary



force low mod. high
direct glancing

restraints: none lap / shoulder
doesn't recall
car seat
air bag deployed
thrown from vehicle
ambulated at scene
long extrication

ROS

loss feeling / power arms / legs
memory loss
headache / neck pain
double vision / hearing loss
nausea / vomiting
abdominal pain

[redacted]

SOCIAL HX [redacted]

PAST HX __negative diabetes Type I Type 2 diet / oral / insulin

Meds- __none / see nurses note
Allergies- __NKDA / see nurses note

☐ Nursing Assessment Reviewed ☐ Vitals Reviewed ☐ Tetanus immun. UTD

PHYSICAL EXAM

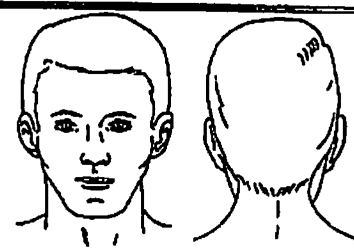
V/S T 97.7 P 91 R 20 BP 146/87

General Appearance
__no acute distress
__alert
__c-collar (PTA / in ED) / backboard
__mild / moderate / severe distress
__anxious / lethargic

HEAD
__no evidence of trauma
__see diagram
__Raccoon eyes / Battle's sign

NECK
__non-tender
__painless ROM
__trachea midline
__see diagram
__vertebral point-tenderness
__muscle spasm / decreased ROM
__pain on movement of neck

__Nexus criteria neg
__midline tenderness / distracting injury
__altered mental status
__recent ETOH



EYES
__PERRL
__EOMI
__unequal pupils R-__mm L-__mm
__EOM entrapment / palsy
__subconjunctival hemorrhage

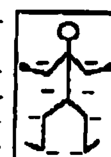
ENT
__nml external inspection
__no dental injury
__hemotympanum
__TM obscured by wax
__clotted nasal blood
__dental injury / malocclusion

RESP / CVS
__chest non-tender
__no ecchymosis
__breath sounds nml
__heart sounds nml
__see diagram (on reverse)
__tenderness / seat belt bruising
__crepitus / subcutaneous emphysema
__splinting / paradoxical movements
__decreased breath sounds
__wheezes / rales / rhonchi
__tachycardia / bradycardia

ABDOMEN
__non-tender
__no organomegaly
__no distention
__see diagram (on reverse)
__tenderness / guarding / rebound
__mass / organomegaly
FHT's

[redacted]

NEURO / PSYCH
__oriented x3
__mood & affect nml
__CN's nml as tested
__sensation & motor nml
__confused / disoriented
__facial asymmetry
__unsteady / ataxic gait
__sensory / motor deficit
__repeats questions



Reflexes

Glasgow Coma Score SCORE=
Eyes Open- spontaneously (4) to voice (3) to pain (2) none (1)
Speech- nml (5) disoriented (4) inapprop. (3) incoherent (2) none (1)
Motor- nml (6) localizes (5) withdraws (4) flexor (3) exten (2) none (1)

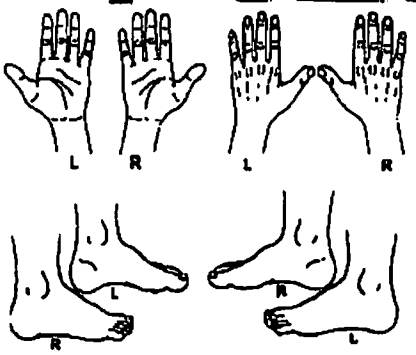
SKIN
- warm, dry
- intact

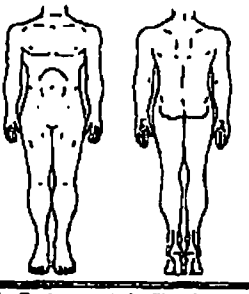
BACK
- no CVA tenderness
- no vertebral tenderness

EXTREMITIES
- atraumatic
- pelvis stable
- hips non-tender
- no pedal edema
- nml ROM
- dilat pulses nml

- see diagram
- crepitus / diaphoresis
- ecchymosis
- see diagram
- vertebral point-tenderness
- CVA tenderness (R / L)
- muscle spasm / limited ROM
- see diagram
- bony point-tenderness
- painful / unable to bear weight
- pulse deficit

Joint Exam:
- limited ROM / ligaments laxity
- joint effusion





T=Tenderness PT=Point Tenderness S=Swelling E=Ecchymosis Lac=Lacerations A=Abrasions B=Burn (0=without m=mild mod=moderate sv=severe)
Ten = Tenderness on palpation (severe)

LABS

[redacted]

PROGRESS Time unchanged improved re-examined

Consult Time:

[redacted]

PROCEDURES

[redacted]

XRAYS Interp. by me Reviewed by me Discsd w/ radiologist

C-Spine T-Spine LS-Spine Pelvis
- nml / NAD
- no fracture
- nml alignment
- soft tissues nml
- reversal / straightening of cerv. lordosis
- DJD / spondylosis / spurring
- fracture non-displaced displaced

CXR
- nml / NAD
- no infiltrates
- nml heart size
- nml mediastinum
- rib fracture
- infiltrate / atelectasis

OTHER: See separate report CT head: dSDH

MVA - 17

RESIDENT / PA SIGNATURE

FACULTY NOTE:

I saw and evaluated the patient. Discussed with resident and agree or disagree with resident's findings and plan as documented in the resident's note. My personal findings are...

HX-

PX-

CLINICAL IMPRESSION:

contusion	arm	R / L	MVA
fracture	elbow	R / L	sprain / strain
stabilized	forearm	R / L	neck thoracic lumbar
restorative	wrist	R / L	sacral
head	hand	R / L	concussion
face	hip	R / L	with LOC w/o LOC
chest	thigh	R / L	
abdomen	knee	R / L	laceration
back	leg	R / L	
shoulder R / L	ankle	R / L	
	foot	R / L	

DISPOSITION: home admitted transferred AMA
Time walkout
CONDITION: unchanged improved stable
Logicare Follow up given: Time:
Discharge Instructions given:

I was present during the entire procedure(s) as listed :

I was present during all critical and key portions of the procedure(s) as listed :

ATTENDING SIGNATURE: Elizabeth Hernandez MD

3/23/2007 10:40 PM Page: 11

PARTICIPATING MEMBER 911 AMBULANCE

NYC 911 SYSTEM PROVIDER AMBULANCE CALL REPORT

NO.: VOL- 3003169

Date MMDDYYYY	Unit	Unit Type	Shield Driver	Shield Tech	CAD No.	Responded From
02/14/2007	16J1	ALS / BLS			0376	

Call Location	Boro	Apt.	PD Badge Number	Precinct	Call Type
E 23rd St / Lexington	M	—		13	MVA

Patients Last Name	First Name	Sex	Age	DOB MMDDYYYY
[illegible]	[illegible]	☐ M ☐ F	[illegible]	[illegible]

Home Address	Apt.	Social Security Number
[illegible]	[illegible]	[illegible]

City	State	Zip Code	Next of Kin	Telephone
[illegible]	NY	[illegible]	[illegible]	[illegible]

Prior Treatment at Scene	By Whom	Prior: ☐ Defibrillation(s), No.: ___ ☐ CPR, Mins.: ___ By: ☐ PD ☐ FD ☐ Other:

REC'D	[illegible]
10-63	[illegible]
10-84	[illegible]
10-82	[illegible]
10-81	[illegible]
AVAIL	[illegible]

MILEAGE: 1

CHIEF COMPLAINT: [illegible]

PRESENTING PROBLEM

MEDICAL *If more than one is checked, circle the primary problem*

☐ Airway Obstruction ☐ CVA / TIA ☐ Hemorrhage ☐ Respiratory Distress ☐ Overdose: ___ Substance
☐ Abdominal pain ☐ Dehydration ☐ Nausea / Vomiting ☐ Respiratory Failure ☐ Poison: ___ Substance
☐ Allergic Reaction ☐ Dizziness ☐ Newborn ☐ Respiratory Arrest
☐ Altered Mental Status ☐ Environmental: ☐ Obvious Death ☐ Seizure
☐ Behavioral ☐ Haz-Mat ☐ Cold ☐ Heat ☐ Ob/Gyn: ☐ Labor ☐ Shock ☐ Fever
☐ Cardiac Arrest ☐ General Malaise ☐ Delivery ___ : ___ ☐ Syncope ☐ Rash
☐ Chest pain ☐ G.I. Distress / Bleed ☐ Psychotic / Suicidal ☐ Unconscious ☐ Other:

TRAUMA Location: [illegible] ☐ Anterior ☐ Posterior Type: [illegible]
☐ Amputation ☐ Burn ☐ Thermal ☐ Chemical ☐ Electrical ☐ Cardiac Arrest ☐ C.N.S. ☐ Crush ☐ FX/Dislocation
☐ Head Trauma ☐ Hemorrhage ☐ Impaled Object ☐ Paralysis ☐ Shock ☒ Soft Tissue ☐ Other:

INDICATE ALL THAT APPLY FOR MEDICAL or TRAUMA
Onset:
Pain:
Quality:
Radiation:
Severity: ☐ Mild ☐ Mod. ☐ Severe
Duration:

MECHANISM OF INJURY
☐ Assault ☐ Cold ☐ Domestic Violence ☐ Fall ☐ G.S.W. ☐ Hazardous Materials ☐ Suspected Child Abuse
☐ Heat ☐ Machinery ☒ MVA: Seatbelts ☒ Yes ☐ No ☐ Pedestrian Struck ☐ Stab ☐ Other: ☐ Suspected Elder Abuse

ASSESSMENT

HISTORY ☐ Denies [illegible]
☐ Amputee ☐ Asthma ☐ Bed Confined ☐ Cancer ☐ Cardiac ☐ CHF ☐ COPD ☐ CVA / TIA ☐ Diabetes ☐ Dialysis
☐ Frail/Debilitated ☐ HIV/AIDS ☐ Hypertension ☐ Incontinent ☐ IVDA ☐ Seizures ☐ TB ☐ Wheelchair Confined ☐ Other:

MEDICATIONS ☐ Denies ☐ Unknown ☐ Not Compliant

ALLERGIES ☐ Denies ☐ Unknown
PCN

TIME	B.P.	PULSE	RESP	GCS	TRAUMA #
[illegible]	125/70	70	14	15	—
[illegible]	130/70	68	14	15	—
:	/				

SKIN: Normal ☒☒ Moist ☐☐ Dry ☐☐
SKIN TEMP.: Normal ☒☒ Warm ☐☐ Cool ☐☐
SKIN COLOR: Normal ☒☒ Pale ☐☐ Cyanotic ☐☐ Flushed ☐☐ Jaundice ☐☐
PUPILS: Normal ☒☒ Dilated ☐☐ R Larger ☐☐ L Larger ☐☐ Constricted ☐☐ Unreactive ☐☐
MENTAL STATUS: Alert ☒☒ Verbal ☐☐ Painful Stimuli ☐☐ Unresponsive ☐☐

TREATMENT

AIRWAY
☐ Abdominal/Chest Thrust
☐ Modified Jaw Thrust
☐ Hyperextension
☐ Oral / Nasal
☐ Suction
☐ DeLee

OXYGEN THERAPY
☐ Bag Valve Mask w/O2
☐ Mouth to Mask
☐ Cannula
☐ Non-Rebreather
☐ Nebulizer
L.P.M.: ___

IMMOBILIZATION
☒ Backboard: ☒ Long ☐ Short
☐ KED ☒ Cervical Collar
☐ Splint: ☐ Fixation ☐ Traction
☒ Head Immobilizer
☐ Other:

BLS and ALS INTERVENTIONS
☐ Albuterol ☐ I.V. ☐ I.O. ☐ Saline Lock
☐ Control Bleeding ☐ Aspirin ☐ Monitor ☐ Defibrillate ☐ 12 Lead
☐ CPR ☐ SAED ☐ Cardiovert ☐ Pacing ☐ Draw Blood
☐ Epi-Pen ☐ ET Tube ☐ NG Tube ☐ Drug Therapy
☐ Heat/Cold Application ☐ Chest Decompression ☐ Needle Cricothyroidotomy
☐ Ipecac ___ cc P.O. ☐ ET Confirm
☐ Insta-Glucose ☐ Irrigation ☐ ALS ASSESSMENT PERFORMED
☐ Other: ALS Provided By: ☐ FD ☐ Vol. ☐ Other

Presumptive Diagnosis: HEAD/NECK/BACK PAIN

Patient Condition: ☐ Critical ☐ Unstable ☐ Potentially Unstable ☒ Stable
☐ DOA ☐ Rigor mortis ☐ Extreme Dependent Lividity ☐ Obvious Death ☐ Decomposition ☐ DNR

COMMENTS

TIME | EKG RHYTHM / MEDICATION(S) | TREATMENT / RESPONSE

UAF 38 y/o F, A&Ox3, Ambulatory on scene [illegible]
was seat belted, denies LOC, [illegible]
and spinal pain, [illegible]
⊖ JVD ⊖ chest [illegible]
[illegible]
[illegible] [illegible]

On-Line Medical | On-Line Medical Control Physician | Number | Termination Time | ☐ Continued

3/23/2007 .10:40 PM

PRESENTING PROBLEM

Altered Mental Status ☐ Environmental: ☐ Haz-Mat ☐ Cold ☐ Heat ☐ Obvious Death ☐ Ob/Gyn: ☐ Labor ☐ Delivery ___ : ___ ☐ Seizure ☐ Shock ☐ Syncope ☐ Unconscious ☐ Fever ☐ Rash ☐ Other:
☐ Behavioral
☐ Cardiac Arrest
☐ Chest pain
☐ General Malaise
☐ G.I. Distress / Bleed
☐ Psychotic / Suicidal

Pain:
Quality:
Radiation:
Severity: ☐ Mild ☐ Mod. ☐ Severe
Duration:

TRAUMA Location: [illegible] ☐ Anterior ☐ Posterior Type: [illegible]
☐ Amputation ☐ Burn ☐ Thermal ☐ Chemical ☐ Electrical ☐ Cardiac Arrest ☐ C.N.S. ☐ Crush ☐ FX/Dislocation
☐ Head Trauma ☐ Hemorrhage ☐ Impaled Object ☐ Paralysis ☐ Shock ☒ Soft Tissue ☐ Other:

MECHANISM OF INJURY
☐ Assault ☐ Cold ☐ Domestic Violence ☐ Fall ☐ G.S.W. ☐ Hazardous Materials ☐ Suspected Child Abuse
☐ Heat ☐ Machinery ☒ MVA: Seatbelts ☒ Yes ☐ No ☐ Pedestrian Struck ☐ Stab ☐ Other: ☐ Suspected Elder Abuse

ASSESSMENT

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MEDICATIONS ☐ Denies ☐ Unknown ☐ Not Compliant

ALLERGIES ☐ Denies ☐ Unknown
NKA

TIME	B.P.	PULSE	RESP	GCS	TRAUMA #
[illegible]	125/70	70	14	15	—
[illegible]	[illegible]	65	14	15	
:	/				

SKIN	SKIN TEMP.	SKIN COLOR	PUPILS	MENTAL STATUS
Normal 1 2 ☒ ☐	Normal 1 2 ☐ ☐	Normal 1 2 ☐ ☐	Normal 1 2 ☐ ☐	Alert 1 2 ☒ ☐
Moist ☐ ☐	Warm ☐ ☐	Pale ☐ ☐	Dilated ☐ ☐	Verbal ☐ ☐
Dry ☐ ☐	Cool ☐ ☐	Cyanotic ☐ ☐	R Larger ☐ ☐	Painful Stimuli ☐ ☐
		Flushed ☐ ☐	L Larger ☐ ☐	Unresponsive ☐ ☐
		Jaundice ☐ ☐	Constricted ☐ ☐	
			Unreactive ☐ ☐	

TREATMENT

AIRWAY
☐ Abdominal/Chest Thrust
☐ Modified Jaw Thrust
☐ Hyperextension
☐ Oral / Nasal
☐ Suction
☐ DeLee

OXYGEN THERAPY
☐ Bag Valve Mask w/O2
☐ Mouth to Mask
☐ Cannula
☐ Non-Rebreather
☐ Nebulizer
L.P.M.:

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☐ KED ☐ Cervical Collar
☐ Splint: ☐ Fixation ☐ Traction
☒ Head Immobilizer
☐ Other

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☐ Albuterol
☐ Control Bleeding ☐ Aspirin
☐ CPR ☐ SAED
☐ Epi-Pen
☐ Heat/Cold Application
☐ Ipecac ___ cc P.O.
☐ Insta-Glucose ☐ Irrigation
☐ Other:
☐ I.V. ☐ I.O. ☐ Saline Lock
☐ Monitor ☐ Defibrillate ☐ 12 Lead
☐ Cardiovert ☐ Pacing ☐ Draw Blood
☐ ET Tube ☐ NG Tube ☐ Drug Therapy
☐ Chest Decompression ☐ Needle Cricothyroidotomy
☐ ET Confirm
☐ ALS ASSESSMENT PERFORMED
ALS Provided By: ☐ FD ☐ Vol. ☐ Other

Presumptive Diagnosis
Head/Neck/Back Pain

Patient Condition: ☐ Critical ☐ Unstable ☐ Potentially Unstable ☒ Stable
☐ DOA ☐ Rigor mortis ☐ Extreme Dependent Lividity ☐ Obvious Death ☐ Decomposition ☐ DNR

COMMENTS

TIME	EKG RHYTHM / MEDICATION(S)	TREATMENT / RESPONSE
[illegible]	[illegible]	[illegible]

☐ Continued

On-Line Medical Control Channel: | On-Line Medical Control Physician Number | Termination Time | Controlled Substance | Amount Administered

C.S. Administered By Name/Shield Signature | URN | Amount Wasted | Witness Name/Title/Signature

Removed to Vehicle By
☐ Chair ☐ Walked ☐ Carried
☐ Scoop/Rat/Stretcher
☐ Other Ambulance

Transported From
☐ Residence ☒ Public Scene
☐ Nursing Facility
☐ Res./Cust. Facility
☐ Other:

Transport Position
☒ Supine ☐ Sitting
☐ Prone ☐ Restrained
☐ Shock
☐ Semi / Full Fowlers
☐ Left Lateral Recumbent

Lights & Siren Used
☒ To Scene (83)
☐ To Destination (82)

Patients Transported by this Vehicle (82)
Hosp #: L5 | # Pts: 1
☐ Transported to Hospital
☐ Transported to Morgue
Hospital Destination

Hospital Selection
☒ Nearest ☐ Pt./Fam Choice
☐ OLMC Contract ☐ Specialty Referral
☐ Hospital Diversion From ___ Hosp. #

Patient Not Transported by this Vehicle
☐ Assisted in Transport (94A) With (Unit #):
☐ Transferred/Relinquished Care To (94)(Unit #):
☐ RMA/AMA (93)
☐ Pronounced on Scene (83)
☐ Triage/On Line Medical Control (93A/95/99A)
☐ Other:

ED Chart No. | Insurance ID Number | ☐ Medicare ☐ Medicaid ☐ Blue Cross ☐ Commercial Insurance ☐ Self Pay | Work Related ☐ Yes ☒ No

Hospital Receiving Agent Signature Time | Supervisor Signature Shield Date

M5 102.15.01 (7/06)

HOSPITAL PATIENT RECORD COPY

[redacted]

CABRINI MEDICAL CENTER

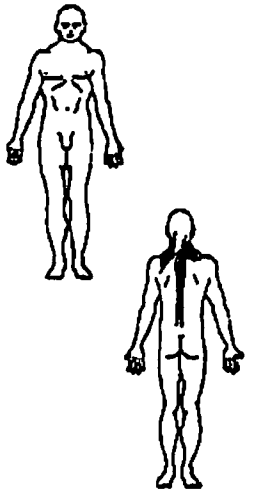
COMPREHENSIVE PAIN ASSESSMENT

Frometa, Adonna

☑ Emergency Department ☐ Ambulatory Services
☐ Hospice ☐ Inpatient Unit: _____
☐ Other: _____

INSTRUCTIONS: Complete when pain is not controlled at time of assessment.

- Source of Information: ☑ Patient ☐ Significant Other/Family ☐ Nursing Assessment - Patient unable to verbalize
  ☐ Other: _____
- Pain Location: Mark Sites



- Patient's Pain Intensity Rating
  ☑ 0-10: 9
  ☐ Smile - Sad _____
  ☑ Verbal: _____
  ☐ Behavioral Indicators
- Physical Findings
  ☐ None ☑ Tender
  ☐ Red ☐ Spasm
  ☐ Swollen ☐ Hot
  ☐ Ecchymotic
  ☐ Other: _____

- Pain Characteristics
  Circle all that apply:
  Aching, Dull, Deep, Sharp, Gnawing, Numb, Stabbing, Crampy, Pressure, Squeezing, Burning, Radiating, Tingling, Touch Sensitive.
- Is the Pain: Right!
  ☑ Constant
  ☐ Intermittent

- Behavioral Indicators:
  Circle all that apply:
  Frowning, Grimacing, Clenched Fists, Hostility, Crying, Moaning, Depression, Grinding Teeth, Restlessness, Clutching/Rubbing Affected Part, Fetal Position, Increased Muscle Tension.

- Pain Intensity Goal: (0 - 10) 0
- When did pain start? At this age.
- Pain Control Goal:
  ☐ sleep comfortably ☐ comfort at rest ☐ comfort with movement ☐ stay alert
  ☑ total pain control ☑ perform activity ☐ other _____
- What makes the pain worse? movement
- Chronic/Pre-existing Pain - What relieves pain? (Check all that apply.)
  ☐ medication ☐ exercise ☐ bed rest ☐ cold
  ☐ heat ☐ massage ☐ distraction ☐ relaxation techniques
  ☐ acupuncture ☐ other _____
- Has there been any medication you have taken that has been effective? no
- What have you done in the past that has been effective in relieving your pain? _____
- Adverse Affect on Daily Life and Activities - Does the pain affect your day to day activities? (Check all that apply.)
  ☐ walking ☐ sitting ☐ standing ☐ exercise ☐ relationships
  ☐ work ☐ bathing ☐ cooking ☐ shopping ☐ other _____
  ☐ family ☐ sleep ☐ concentration ☐ intimacy ☐ other _____
- Comments: _____
- Name of MD Notified: Dr. Hernandez
- Signature & Title: _____ Time: 0520 AM PM Date: 2/19/07

CMC-2036(09/01)

CABRINI
MEDICAL CENTER
227 East 19th Street, New York, NY 10003

PHYSICIAN'S ORDERS

Franetta
Adams

DOCTOR: USE BALLPOINT PEN ONLY.
START NEW SECTION FOR EACH SET OF ORDERS
INCLUDE DATE, TIME AND SIGNATURE FOR EACH
SET OF ORDERS.

DO NOT USE THIS SHEET
UNLESS A RED NUMBER SHOWS →

ALLERGIES:

	MEDICATION (Including Diluent) Name, Dose or Strength, Formulation, Route, Frequency, Duration	Indication Rationale or Reason	
DATE: 2/14/07	1. Rabeprazole 1g PO x1		U.C.
6:10	2. Saft Coffee		DATE:
TIME:	3.		TIME
	4.		
PHYSICIAN'S SIGNATURE [signature]	PAGE/ID #	R.N. SIGNATURE [signature] Verbal Order Read Back [ ]	DATE: 2/14/07 TIME 630
DATE:	1.		U.C.
	2.		DATE:
TIME:	3.		TIME
	4.		
PHYSICIAN'S SIGNATURE	PAGE/ID #	R.N. SIGNATURE Verbal Order Read Back [ ]	DATE: TIME
DATE:	1.		U.C.
	2.		DATE:
TIME:	3.		TIME
	4.		
PHYSICIAN'S SIGNATURE	PAGE/ID #	R.N. SIGNATURE Verbal Order Read Back [ ]	DATE: TIME
DATE:	1.		U.C.
	2.		DATE:
TIME:	3.		TIME
	4.		
PHYSICIAN'S SIGNATURE	PAGE/ID #	R.N. SIGNATURE Verbal Order Read Back [ ]	DATE: TIME

THE SIGNATURE OF THE PRESCRIBER MUST ACCOMPANY EACH ORDER ALONG WITH THEIR PRINTED NAME AND ID #

Authorization Is Given To Dispense Medication By Generic Or Therapeutic Equivalent If Such Is Determined by The Pharmacy And Therapeutics Committee
A Non-Formulary Request Form Is Required If Medications Are Not Included in The Formulary.

CMC 158 (Rev 3/08)

CHART COPY

Cabrini Medical Center

ACKNOWLEDGMENT AND CONSENT

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND OPERATIONS

By signing below, I acknowledge that a copy of the Notice of Privacy Practices has been made available to me. I have been advised of how my health information may be used and disclosed by the hospital and the facilities listed at the beginning of the notice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices (see: Appendix A) explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information:

- *to treat me and arrange for my medical care*
- *to seek and receive payment for services given to me*
- *for the business operations of the hospital, its staff, and the facilities listed at the beginning of the notice*

Adonia Frometa
Signature of Patient or Personal Representative

2/14/07
Date

Adonia Frometa
Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Witness

For Hospital Use Only:

If form is not completed, state the reason:

CMC Employee Signature

Date